ATTACHMENT J-9

TRICARE MANAGEMENT ACTIVITY (TMA)

OWNERSHIP CHANGE APPLICATION FOR A TRICARE-CERTIFIED FACILITY

Facility_____

Please check one appropriate facility/program:

- ☐ Psychiatric partial hospitalization program (PHP)
- ☐ Residential treatment center (RTC)
- ☐ Substance use disorder rehabilitation facility (SUDRF)

All applications must be signed and dated by the Chief Executive Officer.

The above-named facility has made an ownership change application to continue to provide care under TRICARE certification. The signee certifies that the information contained in this application is true and accurately represents the above-named facility.

_____ _____

Chief Executive Officer Date

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OWNERSHIP CHANGE APPLICATION FOR A TRICARE-CERTIFIED FACILITY

Instructions: To allow us to process this application, you must complete all sections of the application.

1.0 Identifying Information:

1.1 Provide the full name, address, IRS tax ID, telephone number, facsimile number, e-mail address, and website address for your facility.

Name of facility PRIOR to ownership change

Name of facility AFTER ownership change Effective Date of ownership change

dba

Physical Address of TRICARE-certified program* City State Zip

Mailing Address (if different) City State Zip

Telephone Number Facsimile Number E-mail address Website Address

PREVIOUS IRS Tax ID Number (EIN)* **NEW** IRS Tax ID Number

* Facilities with programs located at multiple locations must submit a separate complete ownership change application for each location.

1.2 Send All Correspondence To:

Point of Contact Name Title

Street Address PO Box Number

City State Zip

Telephone Number Facsimile Number E-Mail Address

1.3 Corporate Ownership: If the new owner of your facility is a corporation, provide the full name, mailing address, telephone number, and IRS tax ID number of the corporate owner or affiliate.

_____

Name of Corporation

_____

Street Address PO Box Number

_____

City State Zip Code

_____

Telephone Number IRS Tax ID (EIN)

2.0 Composition of Administration: Provide the names, graduate and post-graduate degrees for the new administrative personnel of this facility.

_____

Chief Executive Officer (CEO) Degree(s)

_____

Medical Director(s) Degree(s)

_____

Clinical Director(s) (If Applicable)* Degree(s)

*TRICARE standards for PHPs and RTCs require that the clinical director be a psychiatrist or doctoral level psychologist. The medical director may also serve as the clinical director if he/she fulfills the responsibilities of the clinical director as stated in TRICARE standard I.F for RTCs and TRICARE standard I.E for PHPs. TRICARE Standards for SUDRFs require that the clinical director meet one of the following requirements: is a physician with certification by ASAM, is a physician with one year or 1,000 hours of experience in the treatment of psychoactive substance use disorders, or is a psychiatrist or doctoral level psychologist. The medical director may also serve as the clinical director if he/she fulfills the responsibilities of the clinical director as stated in TRICARE standard I.F for SUDRFs.

3.0 Facility Description

3.1 Does the program(s) requesting certification share physical space or program schedules with other programs such as acute care, RTC, inpatient rehabilitation, or substance use partial hospitalization?

☐ Yes ☐ No If yes, please describe.

_____

3.2 Program/Unit Information: Complete the table below for each program(s)/units(s) that you are requesting to remain certified under the new ownership.

Program/Unit Name	Days of Operation	Hours of Operation	Capacity* M	Capacity* F	Capacity* Total	Age Range From	Age Range To

***** Capacity is defined as the maximum number and mix of patients for whom the program is designed to provide services.

3.3 Specific Requirements for PHPs: PHPs are required to complete section 3.3. RTCs and SUDRFs do not need to complete this section.

PROGRAM REQUIREMENTS	RESPONSE	DOCUMENTATION LOCATION
Does the facility provide academic educational services?	☐ Yes* ☐ No	

*****If yes, please indicate the number of hours per day of academic education.

Program name _____ Hours/day_____

Program name_____ Hours/day_____

Program name_____ Hours/day_____

All facilities must respond to the following sections:

3.4 Specialty programs offered: List any specialty tracks that are included within the program(s) requesting certification (example: dual diagnosis track).

4.0 Program Requirements: Check the appropriate response. Your facility must continue to meet TRICARE standards under the new ownership. **A "yes" response indicates that your facility has reviewed the TRICARE standards for the facility type for which you are applying, and attests that your program(s) meets these standards.** The TRICARE Standards were included for your reference in the application packet. Each requirement below lists the specific standard to which you should refer.

4.1 Program Requirements for All Facilities:

PROGRAM REQUIREMENTS	RESPONSE
a. Does the facility/program have a valid state or federal license to operate under the new ownership? *Refer to TRICARE Standard I.B.*	☐ Yes ☐ No
b. Does the program(s) comply with all TRICARE charting requirements, including weekly notes by the physician or doctoral level psychologist? Note: Inpatient detoxification programs require daily physician notes. *Refer to TRICARE Standard II.K for all charting requirements*	☐ Yes ☐ No
c. Does the facility have a written agreement with an ambulance company to provide emergency transportation? *Refer to TRICARE Standard II.M.1*	☐ Yes ☐ No
d. Does the facility have a written agreement with an authorized hospital for emergency medical/surgical and mental health care? *Refer to TRICARE Standard II.M.1*	☐ Yes ☐ No
e. Does the facility make available during service hours, either directly or through contractual arrangement, the physical health services necessary for patient evaluation and treatment? *Refer to TRICARE Standard II.M.2*	☐ Yes ☐ No
f. When appropriate, does the facility provide, or contract for all pharmacy services? Note: Psychiatric Partial Hospitalization Programs (PHPs) and Substance Use Partial Hospitalization Programs (SUPHs) are not required to provide pharmacy services; PHPs and SUPHs may answer no to this question if patients are responsible for their own medications. *Refer to TRICARE Standard II.M.3*	☐ Yes ☐ No

5.0 Documentation Requirements: Please submit the following documents with this ownership change application. We have included a "Documentation Checklist" to assist you in compiling a complete application. Documents

may be provided on diskette as computer generated files, or as scanned documents, or you may provide hard copies.

Document A: JCAHO Accreditation: RTCs and PHPs must submit documentation to confirm that the JCAHO has been informed of your ownership change. **Submit a copy of the letter from JCAHO which confirms that they have been notified of your ownership change and that your program remains accredited by the JCAHO under the *Comprehensive Accreditation Manual for Behavioral Health Care.*** SUDRFs must submit documentation to confirm that JCAHO or CARF has been informed of the ownership change, and **you must submit a copy of the letter from JCAHO or CARF which confirms that your program remains JCAHO accredited under the *Comprehensive Accreditation Manual for Behavioral Health Care* or CARF accredited.**
Refer to TRICARE Standard I.B

Note: TRICARE standards require that facilities have JCAHO accreditation under the *Comprehensive Accreditation Manual for Behavioral Health Care.* Accreditation under the *Comprehensive Accreditation Manual for Hospitals* is not sufficient.

Document B: Provide a copy of the mission statement, philosophy, goals, objectives, and organizational chart under the new ownership. *Refer to TRICARE Standard I.C and I.D*

Document C: Provide resumes or curriculum vitae for the Administrator/Chief Executive Officer, Medical Director(s), and Clinical Director(s), if applicable.
Refer to TRICARE Standards I.D, I.E, and I.F

Document D: Staffing Table

Complete the attached staffing table for each program requesting certification. The staffing table MUST include each staff member's name, educational degree, position, hours worked per week, program/unit to which staff member is assigned, hours worked on each program, type of license/certification, and license/certification number. *Refer to TRICARE Standards II.A and II.B*.

Please remember to include all clinical staff, including physicians, nurses, therapists, activity therapists, mental health workers, and teachers. Therapists must be master's prepared and licensed or certified by the state in which the facility is located. If they are unlicensed, your facility must confirm that the unlicensed therapists are actively working towards licensure and receive weekly, documented supervision with their clinical entries

countersigned. Activity therapists must be bachelor's prepared and licensed or certified nationally or by the state in which the facility is located. Teachers must be bachelor's prepared and certified by the state in which the facility is located.

RTCs must also include a copy of the RTC nursing schedule for the month prior to the month in which this application is submitted to document that registered nursing coverage is maintained 24 hours per day for the RTC.

Document E: Provide a program schedule and program narrative for each program requesting certification.

The program schedule must include the names of staff designated to lead each group that is listed on the schedule. *Refer to TRICARE Standard II.L*

Note: Psychotherapy groups must be provided and must be led by master's prepared professionals. Activity therapy groups must also be provided. PHPs and RTCs must provide a range of activity therapy groups each week that are led by a bachelor's prepared certified activity, occupational, or expressive therapist. SUDRFs must provide a range of activity therapy groups that are supervised and directed by a bachelor's prepared certified activity, occupational, or expressive therapist. RTCs must provide clinical services SEVEN days per week, which must include either an activity therapy group or a psychotherapy group.

Document F: Provide a copy of the floor plan of the program(s) requesting certification. If the facility is in multiple buildings, clearly designate the buildings by address and location. **Label the programs and room space on the floor plan.** *Refer to TRICARE Standards III.A and III.B*

Document G: Provide any additional information regarding program changes, which have occurred as a result of the ownership change.

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STAFFING TABLE

Name	Degree	Position	Hours/ Week	Program/ Unit Name	Hours/ Program	Type of License/ Certification	License/ Certification No.

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DOCUMENTATION CHECKLIST

We have included this checklist to assist you in compiling a complete application.

No.	Description	
A	JCAHO or CARF notification of ownership change	☐
B	Mission statement, philosophy, goals, objectives, and organizational chart	☐
C	Resumes: administrator (CEO), medical director, clinical director	☐
D	Staffing table	☐
E	Program narrative(s) and program schedule(s) with the names of staff designated to lead each group	☐
F	Floor plan	☐
G	Any additional information regarding changes	☐